

Appendix 1 - Model # 5A

ENCLOSURE I

MINIMUM DOCUMENTATION REQUIREMENTS FOR SAMPLE CASE FILES

The minimum documentation requirements for each sample case listed in Enclosure II are shown below. Each file should contain a checklist confirming that each piece of required documentation is contained in the file. The documentation should be presented in a logical order (for example, chronological in ascending order) and easy to find. If a piece of required documentation is missing, an explanation should be provided on the checklist. If any required piece of documentation is not present in the file, absent an explanation, it will be presumed nonexistent and an error will be noted.

If screen print outs are provided as documentation, a key to interpreting the screen print outs must also be provided.

Any additional documentation/explanations not specifically requested below that would assist the reviewer should also be provided.

CHAPTER 2 – ENROLLMENT AND DISENROLLMENT

Enrollment

WS-ER1 - Applications and Enrollment

- 1) Completed enrollment form
- 2) Documentation of all efforts to obtain additional documentation if enrollment form was incomplete
- 3) Documentation of authorized representative, if applicable
- 4) Acknowledgement notice
- 5) Denial notice, if applicable
- 6) Notice to confirm enrollment
- 7) Screen print showing enrollment date shown in M+CO's internal system and key to interpreting the screen print
- 8) Any other correspondence/information pertinent to the enrollment

WS-ER2 - M+CO Denials

- 1) Completed enrollment form
- 2) Documentation of all efforts to obtain additional documentation if enrollment form was incomplete
- 3) Documentation that the MCO took appropriate action to correct problem or deny application
- 4) Notice for M+CO denial of enrollment
- 5) Any other correspondence/information pertinent to the enrollment

WS-ER3 - CMS Enrollment Rejections

- 1) Completed enrollment form
- 2) Acknowledgement notice
- 3) Transaction reply listing(s) showing rejection
- 4) Documentation that the MCO took appropriate action to correct problem or deny application.
- 5) Copy of retroactive enrollment request sent to RO, if applicable
- 6) Transaction reply listing showing enrollment accepted, if applicable
- 7) Notice for CMS rejection of enrollment or notice to confirm enrollment
- 8) Any other correspondence/information pertinent to the enrollment

WS-ER4 EGHP Enrollments (Code 60s)

- 1) Completed enrollment form
- 2) Any other correspondence/information pertinent to the enrollment

WS-ER5 Applications and Enrollments – Institutional Adjustments

- 1) Name and address of institution (We need this to independently verify that it meets CMS's definition.)
- 2) Name of contact and telephone number at institution
- 3) Documentation that institution meets CMS's definition
- 4) Documentation reflecting period of institutionalization, including date of admission, temporary absences, and date of discharge (if applicable)
- 5) Documentation of monthly verification of institutionalization. Please remember that this documentation is required for the entire review period, not just for the month chosen in the sample.

WS-ER6 State and County Code Change – Monthly Activity Reports

- 1) Address verification form, or equivalent documentation, sent to member
- 2) Documentation of member response, if received
- 3) Documentation of SCC correction sent to CMS, if applicable
- 4) Documentation of disenrollment, if applicable
- 5) Any other correspondence/information pertinent to the enrollment

Disenrollment

WS-DN1 Voluntary Disenrollment through the M+CO

- 1) Disenrollment request by member
- 2) Documentation of authorized representative, if applicable
- 3) Documentation establishing an SEP, if applicable
- 4) Disenrollment acknowledgement notice
- 5) Documentation that any excess premium was refunded, including date of refund (e.g., copy of cancelled check, screen print from system showing day check was mailed, or other screen print documenting premium refund and key to interpreting the screen print), or if there was no refund documentation that none was necessary (e.g., screen print showing payments received or member in zero premium product and key to interpreting the screen print)
- 6) Screen print showing the disenrollment date shown in M+CO's internal system and key to interpreting screen print

- 7) Any other correspondence/information pertinent to the disenrollment of member

WS-DN2 Voluntary Disenrollment through sources other than the M+CO

- 1) Copy of reply listing showing the disenrollment
- 2) Notice to confirm disenrollment
- 3) Documentation that any excess premium was refunded, including date of refund (e.g., copy of cancelled check, screen print from system showing day check was mailed, or other screen print documenting premium refund), or if there was no refund documentation that none was necessary (e.g., screen print showing payments received or member in zero premium product). For all of these screen prints, a key to interpreting them should be provided.
- 4) Any other correspondence/information pertinent to the disenrollment of member

WS-DN3 Involuntary Disenrollment Due to Nonpayment of Premiums

NOTE TO REVIEWERS: This sample should not be requested if the M+CO does not charge plan premiums OR if the M+CO's policy is not to disenroll any members for nonpayment of premiums.

- 1) Documentation establishing the date the M+CO considered the premium delinquent
- 2) All nonpayment notices sent to the member
- 3) Notification of involuntary disenrollment
- 4) Screen print showing the disenrollment date shown in the M+CO's internal systems and key to interpreting the screen print
- 5) Any other correspondence/information pertinent to the disenrollment of member

WS-DN4 Involuntary Disenrollment (Move Out of Service Area)

- 1) Documentation substantiating the date the M+CO was notified of the move (or possible move if from a source other than the member or member's authorized representative)
- 2) Address verification form, or equivalent documentation, sent to member, if applicable
- 3) All correspondence related to the move (or possible move)
- 4) Disenrollment letter
- 5) Screen print showing the disenrollment date shown in the M+CO's internal systems and key to interpreting the screen print
- 6) Documentation that any excess premium was refunded, including date of refund (e.g., copy of cancelled check, screen print from system showing day check was mailed or other screen prints documenting premium refund), or if there was no refund documentation that none was necessary (e.g., screen print showing payments received or member in zero premium product) and key to interpreting the screen prints
- 7) Any other correspondence/information pertinent to the disenrollment of member

CHAPTER 3 – MARKETING

NOTE TO REVIEWERS: This is an optional worksheet. This sample should not be requested if there is no need to review the information.

WS-MR1 Review of Marketing Representative Information

- 1) State licensure information

- 2) Training materials
- 3) Performance Data
- 4) Personnel Actions

CHAPTER 6 – PROVIDER RELATIONS

NOTE TO REVIEWERS: If the M+CO is deemed, this sample should not be requested.

WS-PR1 – Provider Credentialing

Complete credentialing files including:

- 1) Completed Application
- 2) Documentation of verification of license
- 3) Documentation of verification of board certification, if applicable
- 4) Documentation of how the board verifies information for education and training, if applicable
- 5) Documentation of verification of education
- 6) Documentation of verification of clinical privileges, if applicable
- 7) Documentation of verification of malpractice insurance
- 8) Documentation of DEA or CDS certificate, if applicable
- 9) Documentation that M+CO checked the National Practitioner Data Bank
- 10) Documentation that quality of care information was considered in recredentialing process
- 11) Documentation that M+CO reviews the most recently issued Sanction Report
- 12) Documentation that M+CO reviews the most recently issued Medicare opt out list
- 13) Committee decision date and other material used as part of the credentialing process

CHAPTER 11 – CONTRACTS

WS-CN1 – Provider Contracts

Current contract(s) including all BBA amendments and delegation agreements.

- For delegated entities chosen in the sample, provide a signed copy of the contract between the M+CO and the delegated entity.
- For all other contracts chosen in the sample, provide a signed copy of the contract actually signed by the provider or representative of the provider chosen in the sample. For example, if the listed provider is a member of an IPA or PHO, provide the subcontract between the provider and the IPA or PHO, not the contract between the IPA or PHO and the M+CO. However, if the listed provider is an employee of a subcontracting entity (e.g. medical group), please indicate this employment relationship and provide a signed copy of the contract between the M+CO and the subcontracting entity that employs the provider. CMS contracting requirements do not apply to employment agreements.

CHAPTER 13 – CLAIMS, ORGANIZATION DETERMINATIONS, APPEALS, AND GRIEVANCES

Organization Determinations

Please have an ICD-9-CM and CPT code book, or equivalent, available for the reviewers' use.

WS-OC1 – Non-Contracted Provider Paid Claims

The file should contain all information needed to provide a complete auditable history of the claim for all line items, including all pertinent computer screen printouts

- 1) Original claim (or a copy), including documentation of date received and service provided
- 2) Documentation of any requests for additional information (e.g., phone calls/letters to provider or member, additional documentation or medical records received)
- 3) Documentation of date paid (e.g., screen prints showing day check was mailed or other screen prints that document the date paid, copy of cancelled check);
- 4) Provider remittance advice
- 5) Documentation of calculation and payment of interest (based on check date) if clean claim was not paid within 30 days
- 6) Any other correspondence sent to member regarding this claim
- 7) A key for interpreting the claims processing/payment screens and any other system screens included in the file

WS-OC2 – Denied Claims

The file should contain all information needed to provide a complete auditable history of the claim for all line items, including all pertinent computer screen printouts

- 1) Original claim (or a copy), including documentation of date received and service provided
- 2) Documentation of any requests for additional information (e.g., phone calls/ letters to provider or member, additional documentation or medical records received)
- 3) Member denial notice
- 4) Denial notice sent to provider
- 5) Explanation of reason for denial, and documentation supporting the determination, such as clinical information, or assumptions made by system edits
- 6) If claim was denied because the service was bundled provide the documentation of payment of the initial claim
- 7) If claim was denied because it did not meet the definition of emergency or urgent care, provide claims history identifying all claims associated with the episode of care, including whether they were paid or denied
- 8) Medical review notes related to the disposition of the claim
- 9) A key for interpreting the claims processing/payment screens and any other system screens included in the file

WS-OP1 – Standard Pre-Service Denials

- 1) Documentation of date service requested, or discontinuation disputed
- 2) Service requested
- 3) Provider requested, if applicable
- 4) Source of the request
- 5) Notice of extension and documentation supporting the extension, if applicable
- 6) Documentation supporting the determination made by the M+CO
- 7) Member denial notice or notice of discharge/discontinuation

WS-OP2 – Requests for Expedited Pre-Service Organization Determinations

- 1) Documentation of date and time request received
- 2) Service requested
- 3) Provider requested, if applicable
- 4) Source of the request
- 5) Documentation of date, time and content of any verbal notices to the enrollee related to the request, including, if applicable:
 - notice of decision not to expedite
 - notice of extension
 - notice of approval or denial
- 6) Written notices to the enrollee related to the request, including:
 - notice of decision not to expedite, if applicable
 - notice of extension, if applicable
 - notice of approval or denial
- 7) Documentation supporting decision not to expedite, if applicable, and documentation that the case was transferred to the standard process
- 8) Documentation supporting extension, if applicable
- 9) Documentation supporting the determination made by the M+CO

WS-OP3 – Favorable Standard Pre-Service Organization Determinations

NOTE TO REVIEWERS: This is an optional worksheet. This sample should not be requested if there is no need to review the information.

- 1) Documentation of date service requested, or discontinuation disputed
- 2) Service requested
- 3) Provider requested, if applicable
- 4) Notice of extension and documentation supporting the extension, if applicable
- 5) Date request approved, including supporting documentation that indicates approval was communicated to member

Reconsiderations

WS-RC1 – Favorable Claims Reconsiderations

- 1) Initial claim
- 2) Organization determination (initial denial notice)
- 3) Reconsideration request (appeal)
- 4) Documentation of date paid (e.g., day check was mailed – cancelled check, copy of check)
- 5) Provider remittance advice
- 6) Approval notice to member

WS-RC2 – Unfavorable Claims Reconsiderations

NOTE TO REVIEWERS: This sample should be deleted if both elements RC02 and RC03 are found MET based on IRE data.

- 1) Initial claim
- 2) Organization determination (initial denial notice)
- 3) Reconsideration request (appeal)
- 4) Documentation supporting the decision by the M+CO
- 5) Notice to member of decision to forward to Independent Review Entity (IRE)
- 6) Documentation of date case forwarded to IRE
- 7) Copy of the decision by the IRE, ALJ, or DAB
- 8) Documentation of date paid (e.g., screen prints showing day check was mailed or other screen prints that document the date paid, copy of cancelled check), if overturned and key interpreting the screen print
- 9) Provider remittance advice, if overturned
- 10) Notice to IRE that claim was paid, if overturned

WS-RP1 – Favorable Standard Pre-Service Reconsiderations

- 1) Organization determination (initial denial notice)
- 2) Reconsideration request (appeal)
- 3) Extension notice and documentation supporting the extension, if applicable
- 4) Notice to member of approval
- 5) Documentation of date service authorized or provided

WS-RP2 – Unfavorable Standard Pre-Service Reconsiderations

NOTE TO REVIEWERS: This sample should be deleted if both elements RP02 and RP03 are found MET based on IRE data.

- 1) Organization determination (initial denial notice)
- 2) Reconsideration request (appeal)
- 3) Documentation supporting the decision made by the M+CO
- 4) Extension notice and documentation supporting the extension, if applicable
- 5) Notice to member of decision to forward to IRE
- 6) Documentation of date case forwarded to IRE
- 7) Copy of the decision by the IRE, ALJ, or DAB
- 8) Documentation of date service authorized or provided, if overturned
- 9) Notice to IRE that the overturn decision was effectuated, if overturned

WS-RP3 – Requests for Expedited Reconsiderations

- 1) Organization determination (initial denial notice)
- 2) Reconsideration request (appeal)
- 3) Documentation supporting the decision made by the M+CO
- 4) Documentation of date and time request received, and nature of the request
- 5) Source of the request
- 6) Documentation of date service authorized or provided, if M+CO overturns its denial
- 7) Documentation of date, time and content of any verbal notices to the enrollee related to the request, including, if applicable:
 - notice of decision not to expedite
 - notice of extension
 - notice of approval
 - notice to member of decision to forward to IRE
- 8) Any written notices to the enrollee related to the request, including, if applicable:
 - notice of decision not to expedite
 - notice of extension
 - notice of approval
 - notice to member of decision to forward to IRE
- 9) Documentation supporting decision not to expedite, if applicable
- 10) Documentation case was transferred to standard review process, if applicable
- 11) Documentation supporting extension, if applicable

If sent to IRE:

- 12) Documentation of date case forwarded to IRE
- 13) Copy of decision made by IRE, ALJ, or DAB
- 14) documentation of date and time service authorized or provided, if overturned
- 15) notice to IRE that the overturn decision was effectuated, if overturned

Grievances

WS-GV1 – Grievances

- 1) Copy of the appropriate EOC(s) (Note: This is not required to be in every file.)
- 2) Documentation of member grievance, including date received
- 3) Documentation establishing that grievance was resolved according to the evidence of coverage, including documentation of the analysis and resolution of the issue
- 4) Documentation of the date the grievance was resolved
- 5) Any correspondence to the member related to the grievance
- 6) Documentation (e.g., screen prints) of member notification, if notification occurred by telephone and key for interpreting the screen prints
- 7) Any response from the facility or provider against whom the grievance was made
- 8) Grievances related to quality of care should include documentation that the issue was sent to the quality management department for evaluation, and any response from the quality management department